U.S. Japan Bilateral Initiative

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Naturally Occurring Retirement Communities with Supportive Services Program (NORC-SSPs): New York State Model

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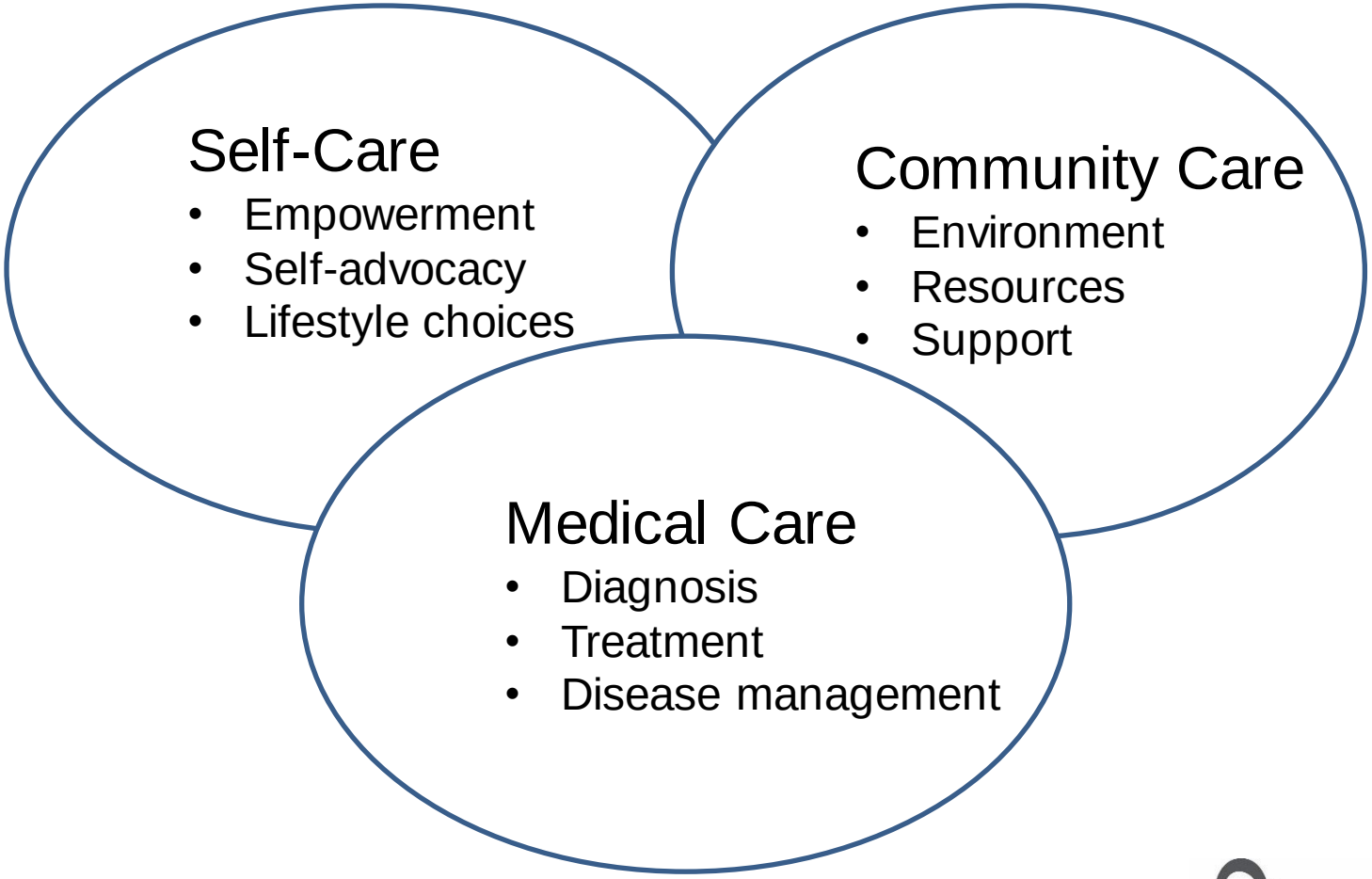
Overview of NY NORC-SSPs

- Collaborative model that coordinates a broad range of social and health services to older adults
- Facilitates and integrates health and social services already in community: Does not duplicate services
- Older adult residents are a resource and partner in program
  - Design
  - Implementation
  - Prioritization of services
  - Governance

NY NORC-SSPs Program Goals

- Maximize health and well-being of older adult residents
- Foster social connectedness within the community
- Empower older adults to take on new roles in the community

NORC-SSPs Framework: Integrates Three Systems of Care



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Reasons for Model Emergence and Public Funding

- Communities have high concentrations of seniors and aging in place
- Number and density of older adults: Critical mass and justify locating services on-site

- Elderly difficulties to remain in home
  - Difficulty coping with growing physical and mental limitations
  - Inadequate social and health care services in the community
  - Difficulty in securing services that are available
- Effective and efficient services can be organized to enable seniors to remain at home as grow older and frailer

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Types of NORC-SSPs

- NORCs are not predominately built for older adults and don't restrict admission solely to older adults
- Classic NORC
  - Apartment building or housing complex constructed with government assistance
  - At least 40% of units have an older adult and at least 250 of the residents of an apartment building are older adults or 500 residents of a housing complex
  - Majority low to moderate income
- Neighborhood NORC
  - Residential dwelling or group of residential dwellings in geographically defined neighborhood
  - **Non-rural:** At least 30% of residents are an older adults/units have an older adult
  - **Rural:** At least 20% of residents are older adults/units have an older adult
  - Low-rise building six stories or less and/or single and/or multi-family homes

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Funding

- State grants (NY budgeted over $4M)
  - Maximum award for classic NORC: $200,000Minimum award for neighborhood NORC: $60,000
- Matching funds of at least 25% of state funding
  - At least 50% of total match contributed by housing development governing body or other owners/managers
  - Cash, in-kind support, or combination
  - Matching funds can include: Dues, fees for service, individual and community contributions, and other funds determined by advisory committee and director
- Members in New York NORC typically do not pay a fee, though may pay for special events[2]

Source: New York State Office for the Aging. February 9, 2017. Classic Naturally Occurring Retirement Community Program and Neighborhood Naturally Occurring Retirement Community Program. Request for Applications.

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Staffing

- FTE Director: Administers and manages day-to-day operations of the program
- Experienced healthcare professional on site with experience aligned with type of healthcare programming offered

- NORCs with funding $100,000 or greater: Additional Staff
  - FTE case manager
  - .5 FTE healthcare management and healthcare assistance (e.g., nurse)

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Determination of Service: Needs Assessment

- Survey administered to residents to determine areas of importance and concern
  - Housing: Perform household chores, finding help to perform home maintenance/repairs
  - Transportation: Medical, grocery store, errands
  - Insurance/Health: Understanding of federal programs, LTSS options, managing chronic conditions, accessing services for mental health needs
  - Nutrition/Food: Access to food; shop and cook for self
  - Services and Supports: Respite services; access to senior centers; in-home personal care services; socialization opportunities
  - Caregiving responsibilities
  - Information and support needed when return from hospital stay
  - Demographics: Age; gender; income

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Health Related Programming and Health Indicators

- Essential component of all NORC-SSPs
- Tailor programs at individual and group level to better meet residents' health care needs
  - Gather and interpret data on health status and risks for older residents
  - Determine needed interventions to improve health
- Identify key health risks in the community: Design, implementation and assessment of interventions targeted for identified health issues
- Follow-up data collection measures the effectiveness of the interventions and identifies new or emerging health risks

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Core Health Care Management and Social Services

- Case management
- Information and assistance
- Healthcare management
- Healthcare assistance and monitoring
- Health indicators
- Health promotion

Optional Health Care Management and Social Services

- Assisted transportation
- Personal care (e.g., housekeeping/chores)
- Home care
- Counseling
- Shopping assistance
- Companionship
- Repair and maintenance
- Education/recreation groups
- Supports groups
- Individual/group transportation
- Outreach

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Provision of Services

- Lead agency manages the provision of services
- Scope and intensity of services determined by needs assessment and appropriateness for the residents
  - Approximately 750 hours of total case management and healthcare management combined
  - 1,000 contacts total of information and assistance and healthcare assistance combined
- NORC-SSPs determine how services paid for based on funding
  - Typically combination of in-kind services and payments

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Partnerships

- Lead agency
  - Overall responsibility for management of the partnership
  - Provides individual and group social work services
- Community partners (public and private enterprises)
  - Work with local businesses and try to get discounts for members
  - Local vendors are often part of the NORC board and may provide limited donations for events
  - Types of partners: Housing management; social service providers; health providers
- Different engagement levels
  - Core: Ongoing role in day-to-day functions
  - Collaborations: Focus on specific projects
    - Examples: Police department education on public safety and home care agency that offers weekly wellness clinics
  - Other community stakeholders: Provide modest support or become involved in one-time events
    - Example: Library that offers office space for a book club

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Example of Neighborhood NORC: Albany Neighborhood NORC

- Staff coordinates services and community resources
- Supportive health and wellness services
  - Home delivered meals
  - Health care assistance
  - Health and blood pressure screenings
  - Exercise and wellness programs
  - Mental health services

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Example of Neighborhood NORC: Albany Neighborhood NORC (cont.)

- Social Enrichment: Social outings, cultural events, educational programs
- Household maintenance
- Other Benefits: Case management, advocacy, information and referral, financial management
- Funders: New York State Office for the Aging
- Supports of $20/year receive discounts on trips and social events
- Community Partners: B'nai Shalom Reform Congregation, Maria College, St. Peter's CHOICES Program, St. Peter's Home Care, Senior Services of Albany

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Lessons Learned

- Menu and priority of services determined by needs of residents
- Team of agencies to organize the supportive services
- Lead agency is a social service provider
- Housing company's financial contribution crucial
  - Support program's operations
  - Invested to making program a success
- Government critical role to sustain programs – financial support

Supports and Services at Home (SASH), Vermont

- Care coordination model anchored in senior housing
- Interdisciplinary team
  - Housing-based staff: SASH coordinator, wellness nurse
  - Network of community-based providers: home health agency, area agency on aging, mental health providers, etc.
- Integrated with state's health reform efforts
  - Medical homes supported by community health teams
  - SASH extender of community health teams
- Statewide expansion supported through Medicare MAPCP demonstration

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Supports and Services at Home (SASH), Vermont

- 2nd annual report results: SASH helping bend Medicare cost curve
  - Based on first 3 years of implementation (July 2011 – June 2014)
  - June 2014 – 49 panels/3,485 participants (analysis includes only housing-based participants)
  - **Growth in annual total Medicare expenditures was $1,536 lower per** participant in early panels (established before April 2012) than beneficiaries in comparison group
  - No statistically significant change in growth for participants in late panels (established after April 2012)

Source: *Support and Services at Home (SASH) Evaluation: First Annual Report*, found at: http://aspe.hhs.gov/daltcp/reports/2014/SASH1.pdf

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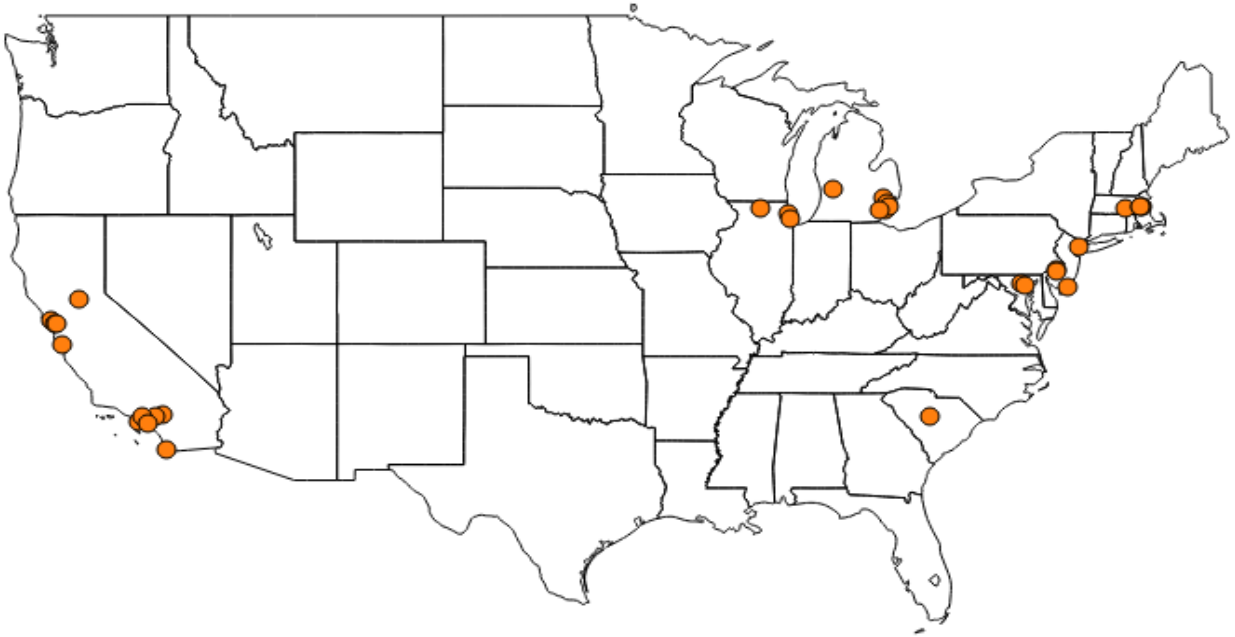
Integrated Wellness in Supportive Housing (IWISH)

HUD Supportive Services Demonstration



Randomized Controlled Trial

- **40 treatment sites**
- **40 control sites**

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IWISH Purpose

- Implement and evaluate a housing-based, person-centered, supportive services and wellness model designed to facilitate successful aging in community by helping residents
  - Proactively address their health and social needs
  - Maximize their independence, wellbeing and quality of life

IWISH Outcomes

- Independent evaluator will study impact on:
  - Healthcare utilization (e.g. emergency department visits, hospitalizations, re-hospitalizations, etc.)
  - Tenure and unit turnover (e.g. evictions and transitions to nursing homes and higher levels of care)

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IWISH Core Components

- Resident Wellness Director & Wellness Nurse Team
- Standardized, comprehensive assessment
- Individual & community healthy aging plan
- Centralized data platform
- Community partnerships
- Evidenced-based programs

Considerations for Japan and Considerations

- Ideal Environment: Densely populated and economies of scale
- Are apartments amenable to having services delivered?
- How to be efficient in service delivery with clustered care?
- What are the areas spending money on older adults and will this intervention address the issues?

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Disclosure

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